A 7515 - 2 F (A) 8/88

On the Cutting Edge

A Series of Community Mental Health Program Models

Services for the Seriously Mentally Ill: A Survey of Community Mental Health Agencies

Series: Administrative Number: 1 Date: February 1988

Published by the National Council of Community Mental Health Centers

Services for the Seriously Mentally Ill:
A Survey of Community Mental Health Agencies

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February 1988

The National Council wishes to thank James W. Stockdill, Chief,
Division of Education and Service Systems Liaison, NIMH
and Rosalyn Bass, Office of Program Analysis and Coordination, NIMH,
for their assistance and support of this project.

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SERVICES FOR THE SERIOUSLY MENTALLY ILL: A SURVEY OF COMMUNITY MENTAL HEALTH AGENCIES

BACKGROUND

It has been maintained that the community mental health center (CMHC) program has failed to serve the most seriously mentally ill citizens of this country, focusing instead on providing services to the so-called "worried well" -- a population whose needs for mental health services are considered to be less critical. This view emerged in early critiques of the CMHC program and has been increasingly articulated during the past several years.

Whether or not the charge accurately applies to a much earlier period in the CMHC program is no longer important, since responsible community mental health service providers, consumers and advocates alike will choose to direct constructive efforts to the present and the future, not to the past. The frequent and singular citation of 10 year-old diagnostic data by community mental health centers' harshest critics is irrelevant. It contributes nothing to the need for information regarding whether, by whom, to what extent, and in what ways community mental health agencies are currently serving the seriously mentally ill. Until now, only anecdotal evidence masquerading as objectivity, in combination with equivocal interpretations of national data showing changes in the staffing of CMHCs, has been available.

The need for this information is more timely than ever, given the complex set of circumstances which has evolved in recent years in community-based mental health care. A national policy of deinstitutionalization has increased the number of mentally ill in need of ambulatory mental health care. The advent of block grant funding has seen state authorities assume additional responsibility for the mental health service systems in their states, including federally funded community mental health centers. For most states, care of the seriously mentally ill has been designated a high (if not the highest) priority concern. Increasing evidence of the seriously mentally ill among the homeless and within jail populations has made local and state governments even more acutely aware of the need for community-based care. At the Federal level, research on schizophrenia and the treatment of mentally ill individuals have also been established as top priorities.

A recent survey conducted by the National Council of Community Mental Health Centers found that agency executive

directors feel that pressure to provide services to seriously mentally ill persons is a critically important trend affecting local community mental health service delivery today ("Survey of Trends Affecting Local Mental Health Agencies," NCCMHC, October 1987). Finally, the 1988, 1987 and 1986 Membership Profile Reports conducted annually by the National Council all identify the seriously/chronically mentally ill as the one population contributing most significantly to the increased demand for community-based mental health services.

The sum total of these factors is that at all governmental levels and for a variety of constituent groups, it is essential to accurately document the extent to which CMHCs are serving the seriously mentally ill, since these agencies are among the primary sources of organized community-based care in this country.

METHODOLOGY

In the Spring of 1987, the National Council of Community Mental Health Centers undertook a nationwide survey to determine the type and level of services being provided to seriously mentally ill individuals in community-based settings.

A brief questionnaire was designed by National Council of Community Mental Health Centers' staff, with consultation from National Institute of Mental Health and local agency personnel. The questionnaire elicited information on caseload, staffing, services and expenditures. It was field-tested with a small group of community mental health agencies and revised into its final form (see Appendix I).

A 50-percent random sample was selected from a comprehensive list of some 2,300 community mental health agencies maintained by the National Council of Community Mental Health Centers. Of the 1,149 surveys originally mailed, 125 were excluded from subsequent analysis because the agencies provided services solely to children or to the mentally retarded, had moved and left no forwarding address or were no longer delivering services. A total of 595 completed surveys was returned by the cut-off date, representing an excellent return rate of 58 percent of the eligible sample.

For purposes of this survey, seriously mentally ill persons were defined as individuals with any one of the following diagnoses: schizophrenia, organic mental disorder, major affective disorder, other psychoses, personality disorder, AND any one of the following characteristics:

(a) has had, in the past two years, one or more episodes of psychiatric treatment more intense than voluntary outpatient care (e.g., outpatient commitment, voluntary or involuntary inpatient, partial hospitalization/day treatment, emergency, alternative home care);

(b) has received supportive residential care during the past two years; OR

(c) shows significant impairment in level of functioning (e.g., receives SSI or SSDI for mental disability, requires help with basic living skills, poor work history.)

As was expected, the response rate from National Council member agencies was higher than that of non-member agencies (73% vs. 52%, respectively). This difference can cause interpretive problems, especially in extrapolating from survey responses to statewide and regional service volume and budget projections. Before extrapolation from survey responses to service patterns throughout the United States is possible, it is necessary to compensate for variance between member and nonmember agencies. Median values were computed for each survey item for National Council of Community Mental Health Centers' members and nonmembers in each state and territory. These median values were then multiplied by the total number of member and nonmember agencies in each geographic region. To estimate per capita service and expenditure rates, census estimates of 1985 state populations 18 years and older were used (Bureau of Census, December 1986).

RESULTS

A. Service Delivery

The survey indicates that community mental health agencies are heavily involved in providing services to persons with severe and persistent mental disorders (Table 1). Community agencies reported an average open caseload on October 1, 1986, of 1,332 persons. Forty-five percent (45%) of these cases meet the established criteria for serious mental illness. Respondents estimated that over half (53%) of all clinical professional time in their agencies was dedicated to serving seriously mentally ill persons. An average of 45% of agency budgets are expended on services to seriously mentally ill clients.

Using median agency caseload figures, it is possible to estimate the number of persons nationwide who are receiving services from community-based mental health agencies. On October 1, 1986, agencies had approximately 2,728,000 persons on their rolls. This figure represented about 1.1% of the total U.S. population. The average community agency had 600 seriously mentally ill clients on its active caseload. This represents 1,228,800 seriously mentally ill adults and older adolescents nationally, or 0.7% of the U.S. population 18 years of age and older.

Case management is generally regarded as a cornerstone of effective community-based service delivery to persons with serious mental disorders, whether offered as a separate, free-standing service component or integrated as an essential function of clinical service responsibilities. Agencies reported an average of 7.8 full time equivalent (FTE) employees who were specifically designated as case managers. The total average agency caseload managed by this group of professionals was 390 clients, representing 65% of all seriously mentally ill persons on active rolls. Caseloads for individual case managers averaged 50 clients, although there was considerable variability among programs. Agencies also reported an average of 29 hours each week in consultation to groups and organizations directly providing services to or otherwise indirectly supporting seriously mentally ill persons.

Table 1

CHARACTERISTICS OF COMMUNITY-BASED AGENCIES SERVING SERIOUSLY MENTALLY ILL PERSONS

	All Agencies (N=595)	NCCMHC Members (N=228)	Non-Members (N=367)
Active caseload	1,332	1,854	1005*
Active SMI caseload	600	809	468
SSI/SSDI recipients on active caseload	272	325	239*
Case managers (FTE)	7.8	9.1	7.0
Case management caseload	390	453	349
Percent of all prof time on behalf of SMI clients	53%	56%	52%
Hours weekly for SMI consultation	29	36	24
Annual agency operating budget	$2,909,496	$3,788,709	$2,340,594
Percent of agency budget for SMI	45%	44%	46%

* Differences between member and nonmember responses significant at $p<.05$ level.

Member agencies of the National Council of Community Mental Health Centers have larger active caseloads and serve a greater number of seriously mentally ill clients. They also have significantly higher budgets than nonmember agencies. The proportion of total agency budgets devoted to the provision of services to the seriously mentally ill is, however, almost equal.

Table 2 reflects the provision of comprehensive community support programming by National Council member and nonmember agencies.

Table 2

PERCENT OF COMMUNITY-BASED PROGRAMS PROVIDING SERVICES FOR THE SERIOUSLY MENTALLY ILL

	All Agencies (N=595)	NCCMHC Members (N=228)	Non-Members (N=367)
DIRECT SERVICES			
Counseling/Therapy	95%	97%	94%
Crisis/Emergency Services	92	96	90 **
Medication Checks	88	93	85 **
Case Management Services	86	93	81 **
Psychosocial Rehabilitation	71	80	66 **
Outreach	68	76	63 **
Transportation	64	75	58 **
Partial Care	62	76	53 **
Residential Care	47	60	40 **
Vocational Rehabilitation	39	47	34 **
Other Services	13	14	12
CONSULTATION ON BEHALF OF SMI CLIENTS			
Families of Seriously Mentally Ill	74%	85%	69%**
Courts	71	76	69
Jails	68	73	66
Nursing Homes	66	73	62 **
Personal Care Homes	47	50	46
Intermediate Care Facilities	46	46	47
Shelter Operators	39	44	36
Other Consultation Sites	20	19	21

** Differences between member and nonmember responses significant at $p<.01$ level.

B. Agency Geographic Service Areas

The geographic location of community agencies affects the kinds of services that they are likely to provide. Four service areas were distinguished for purposes of this study: urban, suburban, rural, and mixed.

Table 3

CHARACTERISTICS OF COMMUNITY-BASED AGENCIES SERVING SERIOUSLY MENTALLY ILL PERSONS, BY TYPE OF GEOGRAPHIC AREA

	Urban (N=132)	Suburban (N=70)	Rural (N=250)	Mixed (N=143)
Active caseload	1510	1021	880	2097
Active SMI caseload	815	460	300	989
SSI/SSDI recipients on active caseload	463	236	143	335
Case managers (FTE)	11.8	7.3	4.6	10.1
Case management caseload	517	307	278	524
Percent of all prof time on behalf of SMI clients	63%	49%	48%	55%
Hours weekly for SMI consultations	39	28	16	45
Annual agency operating budget	$3,851,422	$2,313,579	$1,640,080	$4,520,781
Percent of agency budget for SMI	56%	46%	36%	50%

Table 3 demonstrates that agencies located in urban and mixed areas have larger active caseloads, serve a greater number of seriously mentally ill individuals and have larger budgets than agencies in other types of geographical service areas. More than one-half of the individuals on urban caseloads meet the criteria for serious mental illness. Only just over one-third of those clients of rural agency caseloads are diagnosed as seriously mentally ill. Urban agencies also devote the highest proportion of their staff time to services for seriously mentally ill clients. Similar proportions are also found for the percent of those individuals on agencies' total caseloads receiving SSI or

SSDI support. Urban areas lead the way in receipt of one or the other type of disability income maintenance. While the overall budgets of urban areas are large, mixed geographic service agencies reported the largest budgets of all. Urban agencies allocate the greatest proportion of their financial resources to meeting the needs of seriously mentally ill clients. Mixed area agencies on average allocate one-half of their budgets to services for seriously mentally ill clients.

Although rural agencies appear to devote fewer resources proportionately to seriously mentally ill persons, they are more likely to provide certain services than agencies serving the other types of geographic areas.

Rural agencies, for example, were the most likely of the four groups to provide crisis intervention, medication check, case management, and outreach services. Since rural agencies are often the only human services providers in their geographic areas, they frequently offer a wide range of inexpensive services that are accessible to a broad clientele--the seriously mentally ill, substance abusers, the mentally retarded, the elderly mentally ill, and so on. Rural agencies were also heavily invested in providing consultation to agencies and individuals involved in the care of seriously mentally ill persons, such as nursing homes, jails, courts, personal care homes, and family members. Only agencies serving mixed geographic regions were more likely than rural programs to provide consultation to shelter operators and intermediate care facilities. Rural areas were the least likely of the four groups to provide intensive (and more expensive) community support services such as residential, partial hospitalization/day treatment and vocational rehabilitation.

Urban programs and programs serving mixed geographic areas are not only larger than rural agencies, but they tend also to focus more heaviliy on expensive specialized services for the seriously mentally ill population. Urban or mixed service area agencies were the most likely to provide residential, vocational rehabilitation, transportation, psychosocial rehabilitation, and partial hospitalization/day treatment services. Suburban agencies tended to be at neither extreme: neither the outpatient generalist approach typical of rural areas nor the highly specialized, intensive programs characteristic of the urban and mixed service area agencies.

Of particular interest is the fact that suburban agencies were the least likely to provide transportation for seriously mentally ill persons of the four geographical service area type agencies. Since public transportation in suburban areas is frequently very limited, the absence of organized transportation services may signal a systemic program deficit in suburban agencies.

Table 4 displays differences in the patterns of state hospital discharge among the four service area types. Rural and mixed area programs are the most likely to be informed by state psychiatric hospitals of discharges into their geographic areas, while urban programs are informed of only 67% of such discharges, a significant difference ($p<.05$). Rural agencies also secure aftercare appointments with a high percentage of discharged individuals, experience the lowest "no-show" rates and are most successful in actually linking state hospital and community-based services after discharge. Single portal of entry/exit agreements which provide for notification of discharge back into the community will, therefore, have a significant impact on raising the retention rate of the seriously mentally ill within the continuum of mental health services.

Table 4

STATE HOSPITAL DISCHARGES

	Urban	Suburban	Rural	Mixed
Number of state hospital discharges annually	238	104	83	162
Percent of community agencies informed of state hospital discharges	67%	68%	81%	82%
Percent of state hospital discharges who are offered community-based services	87%	88%	94%	92%
Percent of state hospital discharges who make aftercare appointments	80%	82%	87%	88%
Percent of state hospital discharges who make aftercare appointments but fail to show	24%	17%	15%	19%
Percent of state hospital discharges who actually receive services	61%	68%	74%	71%

Service gaps continue to exist between state hospital discharge and successful aftercare linkage with community-based programs. In urban programs, only three out of every five discharged patients link with community programs. The most commonly reported reasons for the failure of patients to receive aftercare services through community programs are: unwillingness on the part of the patient, referral to private providers, and referral to specialized programs that more specifically target seriously mentally ill persons. In rural areas, there are fewer alternative treatment and support resources for discharged state hospital clients. In addition, there are fewer places where a discharged patient can be anonymous and, therefore, entirely lost to the service system.

C. Regional Service and Financial Patterns

Tables 5 and 6 display regional information on average caseloads of agencies, the percent of persons on agency caseloads that are seriously mentally ill, and average agency budgets and expenditures for seriously mentally ill individuals.

The National Council of Community Mental Health Centers is organized around the ten regions of the Department of Health and Human Services. The largest regional caseload average was found in Region IX, due to a small number of extremely large community mental health programs in California (among the largest in the U.S., in fact). Region X (the northwestern states and Alaska) had the smallest overall caseloads but, interestingly, the largest proportion of seriously mentally ill individuals on agency caseloads of any region in the country.

Table 5

REGIONAL DIFFERENCES IN SERVICES TO SERIOUSLY MENTALLY ILL PERSONS

Region	State	Average Agency Caseload	Percent of SMI in Caseload
I	(CT,ME,MA, NH,RI,VT)	954	35%
II	(NJ,NY,PR VI)	1348	49
III	(DE,DC,MD, PA,VA,WV)	1071	47
IV	(AL,FL,GA,KY, NC,SC,TN,MS)	1796	49
V	(IL,IN,MI, MN,OH,WI)	980	34
VI	(AR,LA,NM, OK,TX)	1386	59
VII	(IA,KS,MO, NE)	983	30
VIII	(CO,MT,ND, SD,UT,WY)	1403	34
IX	(AZ,CA,GU, HI,NV)	3302	58
X	(AK,ID,OR,WA)	378	60
U.S. AVERAGE		1332	45%

There is considerable variability in the proportion of agencies' budgets that are targeted toward serving seriously mentally ill persons. Regions I, II, IX and X all devote at least half of their budgets to seriously mentally ill clients. States in the Midwest (Regions V and VII) devote just over one-third of their budgets to seriously mentally ill clients. This lower proportion of budgets allocated to services for this client population may be a reflection of the rural nature of these areas,

and of the previous observation that rural agencies must often provide a wider range of services to more diverse client populations because they are the only mental health service providers in their geographic service areas.

Table 6

REGIONAL DIFFERENCES IN AGENCY BUDGETS

Region	States	Average Agency Budget	Percent Budget for SMI Services
I	(CT,ME,MA, NH,RI,VT)	$ 3,174,686	50%
II	(NJ,NY,PR,VI)	3,094,683	55
III	(DE,DC,MD, PA,VA,WV)	2,365,650	46
IV	(AL,FL,GA,KY, NC,SC,TN,MS)	3,238,738	47
V	(IL,IN,MI, MN,OH,WI)	2,328,488	37
VI	(AR,LA,NM, OK,TX)	3,236,512	45
VII	(IA,KS,MO,NE)	1,547,235	37
VIII	(CO,MT,ND, SD,UT,WY)	2,903,276	40
IX	(AZ,CA,GU, HI,NV)	3,256,073	52
X	(AK,ID,OR,WA)	984,242	51
U.S. AVERAGE		$ 2,652,850	45%

D. State Service and Financial Patterns

Table 7 reflects the percentage of community mental health agency active caseloads who meet the established criteria for serious mental illness, by state. A very broad range is

represented by survey respondents, from a high of 74.7% in Washington to a low of 4.4% in Wyoming.

Table 7

PERCENTAGE OF COMMUNITY MENTAL HEALTH AGENCY ACTIVE CASELOADS MEETING CRITERIA FOR SERIOUS MENTAL ILLNESS, BY STATE

State	% SMI In Total Agy Caseload	State	% SMI In Total Agy Caseload
Alabama	44.2 %	Montana	27.9 %
Alaska	18.9	Nebraska	40.2
Arizona	29.7	Nevada	26.6
Arkansas	22.1	New Hampshire	24.7
California	52.8	New Jersey	56.3
Colorado	45.5	New Mexico	28.0
Connecticut	26.5	New York	46.1
Delaware	29.8	North Carolina	48.0
D.C.	52.2	North Dakota	32.6
Florida	58.7	Ohio	32.8
Georgia	42.7	Oklahoma	50.6
Hawaii	58.2	Oregon	42.0
Idaho	44.4	Pennsylvania	44.8
Illinois	40.9	Puerto Rico	67.2
Indiana	24.5	Rhode Island	41.2
Iowa	25.7	South Carolina	54.7
Kansas	23.2	South Dakota	35.8
Kentucky	44.9	Tennessee	45.1
Louisiana	70.2	Texas	70.3
Maine	30.1	Utah	40.3
Maryland	53.0	Vermont	59.4
Massachusetts	46.8	Virginia	47.7
Michigan	39.7	Washington	74.7
Minnesota	31.6	West Virginia	34.6
Mississippi	41.6	Wisconsin	27.1
Missouri	30.2	Wyoming	4.4

NATIONAL AVERAGE: 45.0%

Annual budget expenditures devoted to the provision of services for seriously mentally ill clients were combined with the number of individuals meeting the criteria for serious mental illness to produce Table 8, the average annual expenditure for individual seriously mentally ill clients, by state. Once again, a very wide range of differences is noted, from Wisconsin's high of $5,581.25 per year to Puerto Rico's annual rate of $156.30.

Table 8

AVERAGE ANNUAL EXPENDITURE FOR INDIVIDUAL SERIOUSLY MENTALLY ILL CLIENTS, BY STATE

State	$/SMI Client	State	$/SMI Client
Alabama	$ 1367.39	Montana	$ 2170.45
Alaska	2944.00	Nebraska	1763.41
Arizona	1687.93	Nevada	1490.48
Arkansas	1405.45	New Hampshire	5178.57
California	3823.01	New Jersey	3028.40
Colorado	2469.74	New Mexico	1065.71
Connecticut	5318.75	New York	2997.37
Delaware	1658.82	North Carolina	1955.56
D.C.	1920.78	North Dakota	2725.81
Florida	1753.85	Ohio	1728.57
Georgia	2595.56	Oklahoma	3228.24
Hawaii	1009.38	Oregon	2175.86
Idaho	2110.00	Pennsylvania	2778.05
Illinois	2023.68	Puerto Rico	156.30
Indiana	3506.12	Rhode Island	3132.65
Iowa	1025.93	South Carolina	3650.00
Kansas	1151.28	South Dakota	1818.52
Kentucky	963.44	Tennessee	1246.34
Louisiana	711.70	Texas	2202.22
Maine	3262.50	Utah	2899.19
Maryland	1135.48	Vermont	3642.11
Massachusetts	3313.79	Virginia	1674.60
Michigan	3500.00	Washington	3047.69
Minnesota	1024.07	West Virginia	1460.00
Mississippi	940.54	Wisconsin	5581.25
Missouri	4117.14	Wyoming	1853.85

NATIONAL AVERAGE: $2334.45

Additional per capita data, by general population within each state, are displayed in Tables 9-13.

The most accurate and meaningful interpretation of the data presented on a state-by-state basis will result from considering these tables as a group, rather than in isolation of one another. For example, while Washington has one of the lowest community mental health caseload rates per 1000 individuals in the general population of any state in the country, it also has the highest percentage of seriously mentally ill individuals in the average

agency caseload. Almost three-fourths of the state's active community mental health client caseloads are considered to be seriously mentally ill. These two observations taken together provide a clearer understanding of services for the seriously mentally ill in Washington than either one does independently.

Table 9

PER CAPITA COMMUNITY MENTAL HEALTH AGENCY CASELOADS, BY STATE

State	Rate/1000	State	Rate/1000
Alabama	10.4	Montana	15.8
Alaska	13.2	Nebraska	10.2
Arizona	19.5	Nevada	7.9
Arkansas	24.9	New Hampshire	22.8
California	21.4	New Jersey	14.4
Colorado	16.7	New Mexico	12.5
Connecticut	18.1	New York	16.5
Delaware	11.4	North Carolina	15.0
D.C.	29.5	North Dakota	19.0
Florida	13.3	Ohio	17.1
Georgia	21.1	Oklahoma	16.8
Hawaii	5.5	Oregon	6.9
Idaho	4.5	Pennsylvania	18.3
Illinois	9.3	Puerto Rico	17.7
Indiana	20.0	Rhode Island	11.9
Iowa	10.5	South Carolina	11.7
Kansas	16.8	South Dakota	15.1
Kentucky	20.7	Tennessee	18.2
Louisiana	13.4	Texas	6.4
Maine	26.7	Utah	30.8
Maryland	11.7	Vermont	9.6
Massachusetts	12.4	Virginia	13.2
Michigan	11.6	Washington	8.7
Minnesota	17.1	West Virginia	13.0
Mississippi	17.8	Wisconsin	11.8
Missouri	11.6	Wyoming	29.3

NATIONAL AVERAGE: 15.4

Table 10

PER CAPITA SERIOUSLY MENTALLY ILL CLIENTS IN COMMUNITY-BASED TREATMENT, BY STATE

State	Rate/1000	State	Rate/1000
Alabama	4.6	Montana	4.4
Alaska	2.5	Nebraska	4.1
Arizona	5.8	Nevada	2.1
Arkansas	5.5	New Hampshire	5.6
California	11.3	New Jersey	8.1
Colorado	7.6	New Mexico	3.5
Connecticut	4.8	New York	7.6
Delaware	3.4	North Carolina	7.2
D.C.	15.4	North Dakota	6.2
Florida	7.8	Ohio	5.6
Georgia	9.0	Oklahoma	8.5
Hawaii	3.2	Oregon	2.7
Idaho	2.0	Pennsylvania	8.2
Illinois	3.8	Puerto Rico	11.7
Indiana	4.9	Rhode Island	4.9
Iowa	2.7	South Carolina	6.4
Kansas	3.9	South Dakota	5.4
Kentucky	9.3	Tennessee	8.2
Louisiana	9.4	Texas	4.5
Maine	5.6	Utah	12.4
Maryland	6.2	Vermont	5.7
Massachusetts	5.8	Virginia	6.3
Michigan	4.6	Washington	6.5
Minnesota	5.4	West Virginia	4.5
Mississippi	7.4	Wisconsin	3.2
Missouri	3.8	Wyoming	1.3

NATIONAL AVERAGE: 6.0

Table 11

PER CAPITA EXPENDITURES BY COMMUNITY MENTAL HEALTH AGENCIES, BY STATE

State	Rate/1000	State	Rate/1000
Alabama	$ 16.98	Montana	$ 23.02
Alaska	39.61	Nebraska	23.73
Arizona	25.23	Nevada	12.42
Arkansas	29.97	New Hampshire	57.29
California	61.64	New Jersey	39.16
Colorado	36.94	New Mexico	19.15
Connecticut	45.29	New York	43.01
Delaware	13.12	North Carolina	42.99
D.C.	55.07	North Dakota	73.35
Florida	25.38	Ohio	28.70
Georgia	38.64	Oklahoma	49.49
Hawaii	13.85	Oregon	19.24
Idaho	6.50	Pennsylvania	43.27
Illinois	18.58	Puerto Rico	3.10
Indiana	39.13	Rhode Island	28.59
Iowa	11.38	South Carolina	11.43
Kansas	22.76	South Dakota	22.19
Kentucky	36.42	Tennessee	20.70
Louisiana	9.66	Texas	19.81
Maine	52.80	Utah	84.77
Maryland	23.14	Vermont	81.42
Massachusetts	55.24	Virginia	22.73
Michigan	40.91	Washington	24.17
Minnesota	17.33	West Virginia	22.17
Mississippi	16.07	Wisconsin	65.85
Missouri	31.65	Wyoming	22.69

NATIONAL AVERAGE: $32.46

Table 12

PER CAPITA EXPENDITURES BY COMMUNITY MENTAL HEALTH AGENCIES SPECIFICALLY FOR SERIOUSLY MENTALLY ILL PERSONS, BY STATE

State	Rate/1000	State	Rate/1000
Alabama	$ 6.29	Montana	$ 9.55
Alaska	7.36	Nebraska	7.23
Arizona	9.80	Nevada	3.13
Arkansas	7.73	New Hampshire	29.00
California	43.20	New Jersey	24.53
Colorado	18.77	New Mexico	3.73
Connecticut	25.53	New York	22.78
Delaware	5.64	North Carolina	14.08
D.C.	29.58	North Dakota	16.90
Florida	13.68	Ohio	9.68
Georgia	23.36	Oklahoma	27.44
Hawaii	3.23	Oregon	6.31
Idaho	4.22	Pennsylvania	20.38
Illinois	7.69	Puerto Rico	1.86
Indiana	17.18	Rhode Island	15.35
Iowa	2.77	South Carolina	5.78
Kansas	4.49	South Dakota	9.82
Kentucky	8.96	Tennessee	10.22
Louisiana	6.69	Texas	9.91
Maine	18.27	Utah	35.95
Maryland	7.04	Vermont	20.76
Massachusetts	19.22	Virginia	10.55
Michigan	16.10	Washington	19.81
Minnesota	5.53	West Virginia	6.57
Mississippi	6.96	Wisconsin	17.86
Missouri	14.41	Wyoming	2.41

NATIONAL AVERAGE: $13.37

Table 13

PER CAPITA RECEIPT OF SSI/SSDI DISABILITY SUPPORT, BY STATE

State	Rate/1000	State	Rate/1000
Alabama	$ 2.29	Montana	$ 4.05
Alaska	.98	Nebraska	1.38
Arizona	3.29	Nevada	.93
Arkansas	3.16	New Hampshire	3.09
California	4.30	New Jersey	4.85
Colorado	2.29	New Mexico	.98
Connecticut	2.00	New York	2.62
Delaware	1.41	North Carolina	2.72
D.C.	10.40	North Dakota	2.70
Florida	3.86	Ohio	2.83
Georgia	5.35	Oklahoma	5.03
Hawaii	1.53	Oregon	1.76
Idaho	1.37	Pennsylvania	4.43
Illinois	1.53	Puerto Rico	5.19
Indiana	3.34	Rhode Island	2.35
Iowa	1.12	South Carolina	4.02
Kansas	.58	South Dakota	3.94
Kentucky	4.51	Tennessee	4.80
Louisiana	6.48	Texas	1.43
Maine	2.47	Utah	12.16
Maryland	2.46	Vermont	4.92
Massachusetts	3.31	Virginia	3.01
Michigan	3.09	Washington	2.75
Minnesota	2.36	West Virginia	3.08
Mississippi	6.52	Wisconsin	2.42
Missouri	2.69	Wyoming	.54

NATIONAL AVERAGE: $3.28

Computation of a series of Pearson Product Moment Correlation Coefficients allows interpretation of these data that should prove particularly valuable in guiding community mental health program development on behalf of seriously mentally ill clients:

- The amount of money allocated to fund services for the seriously mentally ill is a function of the amount of all funding available for community mental health services in general ($r=.65$, $p=.000$);

- The amount of money expended per SMI client is not related to the number of seriously mentally ill clients in the overall agency caseload ($r=-.06$).

In addition, combining the results of this survey with state mental health expenditure data recently produced by the National Association of State Mental Health Program Directors reveals that the greater the proportion of available state dollars allocated to community mental health services (as compared to state hospitals), the greater will be:

a) the overall community mental health agency caseload ($r=.36$, $p=.01$);

b) the size of caseloads of the seriously mentally ill in community agencies ($r=.35$, $p=.01$);

c) the amount of money allocated by community agencies to provide services to seriously mentally ill clients ($r=.59$, $p=.000$); and,

d) the proportion of the seriously mentally ill receiving SSI/SSDI support ($r=.52$, $p=.000$).

CONCLUSIONS

This survey was not designed to assess the quality of community mental health services currently being delivered to the seriously mentally ill. Rather, its fundamental objective was to determine the presence or absence of a variety of services in order to more accurately inform ongoing discussions among mental health practitioners, policy-makers and advocates for community-based treatment of seriously mentally ill individuals.

The most significant conclusion to be drawn from the survey is that the community mental health service system in this country is responding to the needs of the seriously mentally ill population with a substantial proportion of its professional and financial resources.

More specifically:

- The proportion of clients on typical community mental health agency caseloads who are seriously mentally ill averages 45%;
- Over one-half of the total professional staff time available to community-based programs is devoted to providing services to the seriously mentally ill, while just under one-half of the financial resources support services to this group of clients;
- A broad range of community support services is typically available to seriously mentally ill individuals, their families and other community-based service providers;
- From 87%-92% of those individuals annually discharged from state psychiatric hospitals are offered community-based mental health services, while from 61%-74% actually receive services.

Community mental health professionals, policy-makers and advocates should now focus their energies on an objective and thoughtful analysis of the adequacy and appropriateness (i.e., quality) of community-based services for the seriously mentally ill population, particularly since it appears that:

1) in some parts of the country, there is an absence of the kinds of services most needed by seriously mentally ill individuals, such as residential, outreach, case management and psychosocial/rehabilitation support;

2) while a majority of the individuals discharged from state/regional inpatient settings do make contact with a community mental health agency, substantial numbers still do not; and

3) no systematic method of collecting accurate information on the effectiveness of services being delivered to the seriously mentally ill population in this country currently exists.

As financing increasingly drives the service system, the ability to demonstrate an acceptable level of quality of care will become more and more critical. That is the task now at hand.

National Council of Community Mental Health Centers

SURVEY OF COMMUNITY MENTAL HEALTH PROGRAMS: SERVICES TO SERIOUSLY MENTALLY ILL INDIVIDUALS

INSTRUCTIONS: Please complete all questions on this survey form. **If the data is not available from your information system, please estimate and circle the estimated response(s).**

1-4. Name of Person Completing Survey: _____

Title: _____

Telephone: _____

Please describe the type of area your agency serves (if more than one type of area is included please give approximate percentage of each):

_____Urban

_____Suburban

_____Rural

CASELOAD

5. Total active caseload as of October 1, 1986: _____
(Active caseload defined as those persons on the roll and having received a service from your community mental health program within the past 90 days.)

6. Of total active caseload (item 5 above), total number of seriously mentally ill clients: _____
"Seriously mentally ill" is defined as adults or older adolescents with any of the following diagnoses: schizophrenia, organic mental disorder, major affective disorder, other psychoses, personality disorder; AND **ANY ONE** of the following characteristics:

(a) has had, in the past two years, one or more episodes of psychiatric treatment more intense than voluntary outpatient care (e.g., outpatient commitment, voluntary or involuntary inpatient, partial hospitalization/day treatment, emergency, alternative home care);

(b) has received supportive residential care during the past two years;

OR

(c) shows significant impairment in level of functioning (e.g., receives SSI or SSDI for mental disability, requires help with basic living skills, poor work history.)

7. Of active caseload reported in item 6 above, how many are receiving SSI or SSDI for mental disability? _____

STAFFING

8. How many full time equivalent (FTE) employees do you have on your staff specifically designated as case managers? _____

9. What is the total combined caseload of these case managers? _____

10. Estimate the percent of total professional staff time devoted to serving the population defined in item 6 above: _____

SERVICES

Please check any of these services which your agency provides to the seriously mentally ill:

11. _____ Crisis or emergency service
_____ Med checks
_____ Partial care
_____ Residential care
_____ Vocational rehabilitation
_____ Other (specify) _____
_____ Transportation
_____ Case management services
_____ Psychosocial rehabilitation
_____ Outreach
_____ Counseling/psychotherapy

12.-13. Is your agency informed of all persons discharged by the state mental hospital(s) into your service area?

_____ Yes
_____ No (If no, explain) _____

14. How many persons were discharged from the state mental hospital(s) into your service area during January 1, 1986 to December 31, 1986? (If estimate, circle the number) _____

15.-16. Of those discharged from the state mental hospital(s) into your service area, what percentage were offered services by your agency? _____

If less than 100%, explain _____

17. Of those to whom you offered services, what percent accepted service; that is, agreed to making an aftercare appointment? _____

18. Of those who agreed to making an aftercare appointment, what percent were "no-shows"? _____

CONSULTATION

19. Does your agency provide consultation to any of the following **on behalf of** seriously mentally ill individuals? (Check all that apply)

_____ Personal care homes
_____ Nursing homes
_____ Jails
_____ Courts
_____ Intermediate care facilities
_____ Shelter operators
_____ Families of SMI individuals
_____ Other (specify) _____

20. Approximately how many hours per week are devoted to such consultation by your professional staff? _____

EXPENDITURES

21. What was your agency's overall annual budget for the past calendar or fiscal year? _____

22. What percent of this annual budget was used for services for the severely mentally ill? _____

23. Do you have any general comments you'd like to make? _____

Thank you for taking the time to complete and return this questionnaire by April 1, 1987. If you have questions, please contact:

Bruce D. Emery or Carol E. Gill, NCCMHC, 6101 Montrose Road, Suite 360, Rockville, MD 20852
(301) 984-6200

COMMUNITY MENTAL HEALTH AGENCIES RESPONDING TO SURVEY, BY STATE

	Number of Responses:					Number of Responses:			
	<10	10-19	20-29	30+		<10	10-19	20-29	30+
AL	X				MT	X			
AK	X				NB	X			
AZ	X				NV	X			
AR	X				NH	X			
CA				X	NJ			X	
CO	X				NM	X			
CT		X			NY				X
DE	X				NC		X		
DC	X				ND	X			
FL			X		OH				X
GA		X			OK		X		
HI	X				OR		X		
ID	X				PA				X
IL				X	PR	X			
IN		X			RI	X			
IA		X			SC	X			
KS	X				SD	X			
KY	X				TN		X		
LA	X				TX		X		
ME	X				UT	X			
MD		X			VT	X			
MA			X		VA		X		
MI			X		WA		X		
MN		X			WV	X			
MS	X				WI		X		
MO		X			WY	X			

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